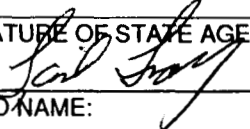
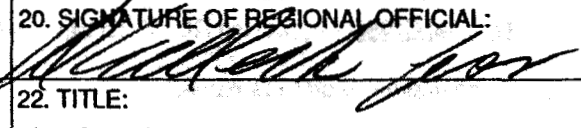


<b>1. TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: <u>0 1 — 0 1 8</u>	2. STATE: Montana
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE 07/01/01	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION:  Title 42		7. FEDERAL BUDGET IMPACT: a. FFY 2000 \$ 02,800 b. FFY 2001 \$ 011,437.00	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Pages 1 and 2 of attachment 4.19B		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Pages 1 and 2 of attachment 4.19B	
10. SUBJECT OF AMENDMENT:  Durable Medical Equipment			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      Single Agency Director <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Gail Gray Department of Public Health & Human Services PO Box 202951 Helena MT 59620-2951  Attn: Jean Robertson 406-444-9524	
13. TYPED NAME: Gail Gray			
14. TITLE: Director			
15. DATE SUBMITTED: 08/30/01			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: August 31, 2001		18. DATE APPROVED: 10/12/01	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2001		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Spencer K. Ericson		22. TITLE: Acting Associate Regional Administrator	
23. REMARKS:			

**MONTANA**

- I. Reimbursement for Durable Medical Equipment and Supplies shall not exceed the lower of:
- A. The provider's Usual and Customary Charge ("UCC") amount submitted on the claim to Medicaid.
  - B. The Department's fee schedule as follows:
    - 1. Specified fees for:

Durable Medical Equipment and supplies for which there is not a statistically significant volume\* or which includes variable modifications. These are reimbursed at 90% of UCC.
    - 2. Wheelchairs and accessories will be reimbursed at 80% of UCC.
    - 3. Rental items listed as "capped" rental under Medicaid are limited to 12 months rental. Rental for items needing frequent servicing as classified by Medicare can be rented as long as the medical necessity exists. Other rentals are limited to Medicaid purchase fee, or if no fee exists, the suppliers' purchase price as long as it is reasonable.
      - (a) . rental fees include all necessary supplies needed to operate rented equipment for the month.

\*A statistically significant volume of service is a number of services billed to the Medicaid program during a calendar year which will provide sufficient data for calculating a reasonable prevailing charge, using the Medicaid methods.

II. Reimbursement for home infusion therapy shall not exceed the lowest of:

- A. The provider's usual and customary charge of the therapy to the general public; or
- B. The Medicaid fee established as a daily rate for home infusion therapy providers.

Daily rates for various therapies were established based on the usual and customary charges reported by home infusion therapy providers in the State of Montana. The daily rate for each therapy was derived by averaging the individual provider charges. The Department worked with providers to reach agreement on reimbursement for individuals' infusion therapies.